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MEDICAID IN SCHOOLS

Poor Oversight and Improper Payments Compromise Potential Benefit

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Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you address the issue of Medicaid expenditures for school-based health services and administrative costs. Because Medicaid is a federal-state partnership, the federal government is responsible for paying a share of costs incurred by the states to serve Medicaid's 41 million low-income beneficiaries, including 13 million school-aged children. Medicaid helps finance certain health services that eligible children, including those with disabilities, receive in schools, such as diagnostic screening and physical therapy. Medicaid is also authorized to reimburse schools' costs for performing certain administrative activities, such as conducting outreach to help enroll children in Medicaid and providing referrals to qualified providers.

In June 1999, we testified before your Committee about multimillion-dollar increases in Medicaid reimbursements for administrative activities in 10 states and the need for more federal and state oversight of these growing expenditures.[1] At that time, we found that weak and inconsistent control over the review and approval of claims for school-based administrative activities created an environment in which inappropriate claims could result in excessive Medicaid reimbursements. You subsequently asked us to expand our analysis of Medicaid reimbursement of school-based administrative activities and to examine states' use of "bundled" rates for school-based health services.[2] Our remarks are based on our report being issued today and will focus on (1) the magnitude of states' claims for school-based health services and administrative activities, (2) the appropriateness of the methods used to determine how much Medicaid pays for these services, (3) the extent to which school districts directly benefit from federal Medicaid reimbursements, and (4) the adequacy of the Health Care Financing Administration's (HCFA) oversight of school-based claims.[3]

Our findings are based on a survey of all 50 states and the District of Columbia; work in 7 states that HCFA identified as paying for health

[1]See *Medicaid: Questionable Practices Boost Federal Payments for School-Based Services* (GAO/T-HEHS-99-148, June 17, 1999).

[2]Bundled rates are single payments for a package of various services that eligible special education children may need over a specified period of time; a fixed amount is paid per child on the basis of the services the child is expected to require, not on the basis of the services the child actually receives.

[3]See *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight* (GAO/HEHS/OSI-00-69, Apr. 5, 2000).

services using a bundled, rather than a fee-for-service, approach; and work in 17 states we identified as submitting claims for administrative activities. We also conducted investigative work in two states where we identified abusive or potentially fraudulent practices associated with claims for administrative activities or fee-for-service health payments.

In summary, despite growing expenditures for school-based Medicaid services and activities, the potential benefits to schools and the children they serve are being compromised by poor HCFA guidance and oversight and by improper payments that divert public funding from its intended purpose. In total, 47 states and the District of Columbia have reported $2.3 billion in Medicaid expenditures for school-based activities for the latest year for which they have data. Although this spending level reflects a small share of total Medicaid expenditures, more schools are expressing interest in availing themselves of Medicaid as a source of funds, especially to reimburse administrative activities, which creates the potential for continuing expenditure growth.

Payment for covered services for Medicaid-eligible children is not at issue. But methods used by some school districts and states to claim Medicaid reimbursement for school-based services lack sufficient controls to ensure that these are legitimate claims. For example:

- Bundled payment methods that seven states use to pay for health services have failed in some cases to take into account variations in service needs among children and have often lacked assurances that services paid for were provided. HCFA last year banned the use of bundled rates because of concerns about their development and use. However, we believe that it would be better for HCFA to work with states and schools to build in these missing assurances rather than to ban the use of bundled rates altogether.

- Poor guidance and oversight have resulted in improper payments in at least 2 of the 17 states that allowed schools to submit claims for administrative activities costs. Our work in Michigan alone identified $28 million in federal reimbursement for improper payments for administrative activity claims over 2 recent years. The lack of effective controls in other states could allow comparable improprieties to occur elsewhere.

Despite the significant level of Medicaid payments for school-based services in some states, school districts may receive little in direct reimbursements because of certain funding arrangements among schools, states, and private firms contracting with them. Seven states retain from

50 to 85 percent of federal reimbursement for Medicaid school-based claims. In addition, some school districts may pay private firms up to 25 percent of their federal Medicaid reimbursement. These firms often help schools develop claiming methodologies, train school personnel to apply these methods, and submit the claims for reimbursement. As a result of these arrangements, schools may end up with as little as $7.50 for every $100 claimed. These funding arrangements can create reduced incentives for appropriate program oversight and an environment for opportunism that drains funds away from their intended purposes.

HCFA has historically provided little or inconsistent direction and oversight of Medicaid reimbursements for school-based claims, which has contributed to the problems we have identified. For example, some HCFA regional offices allowed payments to be made without approving the methods proposed by some states to claim reimbursement for administrative activities. HCFA has recently focused more attention on these issues by reviewing the claims for school-based administrative activities by at least one regional office and developing a draft school-based administrative claiming guide. However, states are still awaiting further guidance on bundled rates and allowable transportation costs for children with special needs.

We are making recommendations to the Administrator of HCFA aimed at improving the development and consistent use of clear policies and appropriate oversight for school-based Medicaid services. HCFA generally has agreed with our findings and is already taking steps to respond to these recommendations. We are also making referrals to the U.S. Attorney's Offices for those instances in which we have uncovered evidence of inappropriate and potentially fraudulent claims.

Background

Medicaid is a joint federal-state program that in fiscal year 1998 spent about $177 billion to finance health coverage for 41 million low-income individuals, 13 million of whom were school-aged children. States operate their programs within broad federal requirements and can elect to cover a range of optional populations and benefits. Medicaid costs shared by the federal government and the states fall under one of two categories: medical assistance (or "health services") and administrative activities. Each state program's federal and state funding shares of health services payments are determined through a statutory matching formula. Under this formula, the federal share ranges from 50 to 83 percent, depending on a state's per capita income in relationship to the national average. The federal share of costs for administrative activities varies by the type of costs incurred, but most administrative costs are shared equally between

the federal government and the individual state.[4] Over 95 percent of Medicaid's $177 billion in total expenditures in fiscal year 1998 was spent on health services.

Schools can help identify, enroll, and provide Medicaid services to eligible low-income children, and states are authorized to use their Medicaid programs to help pay for certain health care services delivered to these children in schools. In addition, Medicaid is authorized to cover health services provided to Medicaid-eligible children under the Individuals With Disabilities Education Act (IDEA). In particular, IDEA obligates schools to identify and provide the "related services" that are required to help a child with a disability benefit from special education, including transportation, speech therapy, and physical and occupational therapy. Because some services required to address the specific needs of a child with a disability are health-related, Medicaid is an attractive option for funding health-related IDEA services for Medicaid-eligible children.

Commonly provided school-based health services that qualify for Medicaid reimbursement include physical, occupational, and speech therapy as well as diagnostic, preventive, and rehabilitative services. Schools that submit claims to their state Medicaid agency for reimbursement for health services must meet Medicaid provider qualifications established by the state and must have a provider agreement with the state Medicaid agency. Payment rates are established by the state Medicaid agency and described in a state plan that is approved by HCFA. Although states have broad discretion in establishing payment rates, they must be reasonable and sufficient to ensure the provision of quality services and access to care.

Until recently, states have been allowed to develop methods to create bundled payments for a specified group of services, which in most instances means a fixed payment for all services a child receives during a set period of time, such as a day or month. However, in a May 21, 1999, letter to state Medicaid directors, HCFA prohibited states' use of this approach, having concluded that bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments. HCFA informed states that it would not be considering further proposals by states to use a bundled rate payment system and directed states with

[4]Certain administrative expenditures are eligible for higher federal matching funds. For example, federal matching funds pay 90 percent of costs for the development of automated information systems and 75 percent of costs for some administrative activities performed by skilled professional medical personnel.

bundled rates to develop and prospectively implement an alternate reimbursement methodology. HCFA expected states to come into compliance with its May 21, 1999, letter within a reasonable time frame and stated it would consider taking action if this did not occur. While HCFA expects to issue further clarification on bundled rates, states with approved bundled rates continue to use them.

Schools may also receive reimbursement for the costs of performing administrative activities related to Medicaid, such as Medicaid outreach, application assistance, and coordination and monitoring of health services. Unlike the requirements for health services claims, a school does not need to become a qualified Medicaid provider to submit administrative activity claims. However, there must be (1) either an interagency agreement, or a contract, that defines the relationship between the state Medicaid agency and the school district and (2) an acceptable reimbursement methodology for calculating allowable costs of administrative activities. States must abide by the cost allocation principles described in Office of Management and Budget Circular A-87, which requires, among other things, that costs be "necessary and reasonable" and "allocable" to the Medicaid program.

In August 1997, HCFA issued a technical assistance guide for Medicaid claims for school-based services that provides general guidelines regarding Medicaid reimbursement for the costs of school health services and administrative activities.[5] More recently, HCFA's May 21, 1999, letter to state Medicaid directors, in addition to addressing bundled rates, also attempted to clarify several policies, including payments for transportation for children with disabilities. The letter stated that HCFA was in the process of updating its guiding principles related to claims for school-based administrative activities costs. In February 2000, HCFA issued for comment a new draft technical assistance guide aimed at clarifying guidance for submitting school-based administrative claims.[6]

[5]See HCFA, Center for Medicaid and State Operations, *Medicaid and School Health: A Technical Assistance Guide* (Washington, D.C.: HCFA, Aug. 1997).

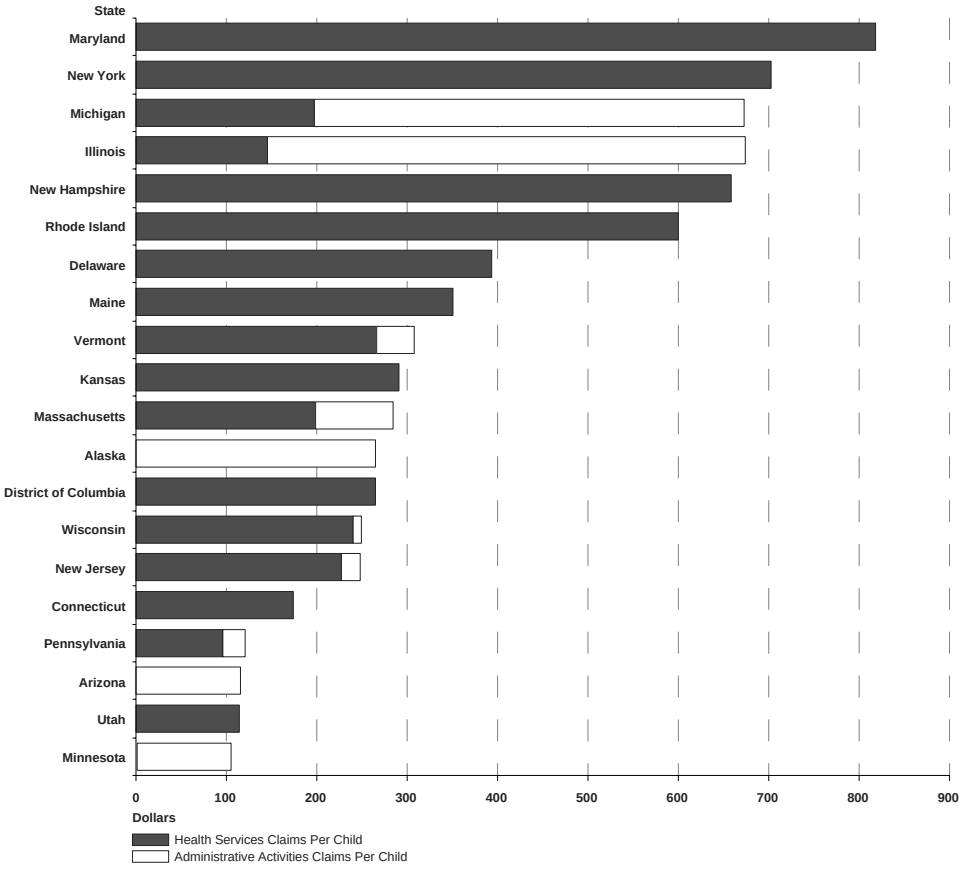
[6]See HCFA, *Medicaid School-based Administrative Claiming Guide* (Draft) (Washington, D.C.: HCFA, Feb. 2000). The guide can be accessed at http://www.hcfa.gov/medicaid/schools/machmpg.htm.

Medicaid School-Based Activities Involve a Variety of Practices Across States

Schools in 47 states and the District of Columbia obtain Medicaid payment to some degree for school-based health services, administrative activities, or both. These payments totaled $2.3 billion for the latest year for which data were available.[7] Medicaid payments to schools ranged from a high of $820 per Medicaid-eligible child in Maryland to about 5 cents per Medicaid-eligible child in Mississippi. Figure 1 shows the 19 states, and the District of Columbia, with the highest average expenditures per Medicaid-eligible child for school-based services. (App. I provides more detail on school-based claims for all states.)

[7]States were asked to provide school-based claims data for the most recent fiscal year for which they were available, which for approximately half of the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data for periods before July 1997.

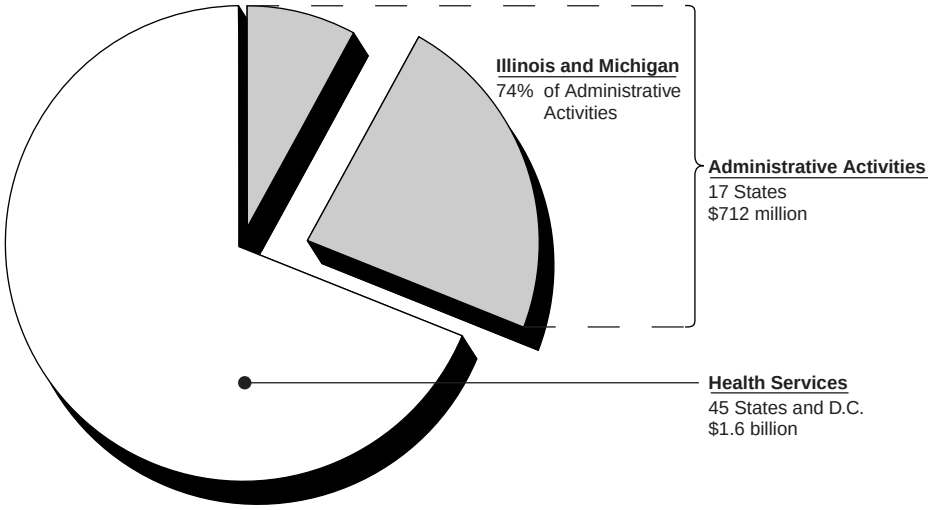
Figure 1: Highest Average Claims Per Medicaid-Eligible Child (19 States and the District of Columbia)



Source: GAO analysis of state-reported claims data and HCFA's fiscal year 1997 eligibility data (2082 report).

The majority of Medicaid payments—about $1.6 billion—were for health services provided by schools in 45 states and the District of Columbia, and about $712 million were for administrative activities billed by schools in 17 states. Although schools in 17 states submit claims for reimbursement of Medicaid-related administrative activities, 2 states—Michigan and Illinois—accounted for 74 percent of all school-based administrative activity payments. (See fig. 2.)

Figure 2: $2.3 Billion Claimed for School-Based Medicaid Reimbursement



Source: GAO survey of states.

The school-based administrative claims of a few states have grown rapidly and now constitute a significant share of these states' total administrative costs for all Medicaid program activities. For example, school-based claims represented 47 percent and 46 percent of total Medicaid administrative claims for Michigan and Illinois, respectively. Other states—Alaska, Arizona, and Washington—had school-based claims representing about 20 percent of their total Medicaid administrative expenditures. (See table 1.) Alaska, Illinois, Michigan, and Minnesota each showed average annual growth rates for school-based administrative expenditures that were at least twice as high as the growth rate of other Medicaid administrative expenditures .

Table 1: States' Medicaid School-Based Administrative Claims as a Percentage of Total Medicaid Administrative Expenditures

State	School-based Medicaid administrative claims (in thousands)	Total Medicaid administrative expenditures (in thousands)[a]	Percentage of total administrative expenditures
Michigan	$224,167	$477,138	47
Illinois	302,687	661,188	46
Arizona	25,795	131,577	20
Washington[b]	18,394	91,745	20
Alaska	7,780	40,662	19
New Mexico	4,909	32,078	15
Florida	38,451	289,625	13
Minnesota	23,495	209,412	11
Massachusetts[c]	19,500	190,669	10
Missouri	11,104	131,024	8
Vermont	1,757	35,659	5
Pennsylvania	13,952	387,262	4
New Jersey	5,657	253,991	2
Texas	11,662	576,952	2
Iowa	1,084	70,125	2
Wisconsin	1,591	138,555	1
California	288	1,227,657	Less than .02

Note: States provided administrative claims data for school-based services from the most recent fiscal year for which data were available. Most states provided data from the year ending June 30, 1999, while two states provided data from calendar year 1998, two states provided federal fiscal year 1998 data, and three states provided data from state fiscal year 1998 (July 1, 1997–June 30, 1998).

[a] States provided total Medicaid administrative expenditures for the same period as for the school-based administrative claims data.

[b] Washington provided school-based administrative claims data for the year ending August 31, 1999, and total Medicaid administrative expenditures for federal fiscal year 1999 (October 1, 1998–September 30, 1999).

[c] Massachusetts provided 6 months of school-based administrative claims data, which we extrapolated to reflect a full year of claims.

Source: State-reported claims data.

Certain Methods Used to Claim Medicaid Reimbursement Lack Sufficient Controls

Some methods used to claim Medicaid reimbursement do not adequately ensure that health services are provided or that administrative activity costs are properly identified and reimbursed. Bundled payment methods used to claim Medicaid reimbursement may lack sufficient controls to ensure that health services paid for are actually provided and may not differentiate levels of need among children. In addition, our investigation of fee-for-service payments for health services in one state also identified inappropriate practices that resulted in improper payments by Medicaid. Similarly, poor controls over what constitutes an allowable administrative activity have resulted in millions of dollars of improper Medicaid reimbursements.

Some States' Bundled Payment Methods for Health Services Lack Sufficient Accountability

Bundled payments are somewhat comparable to capitation payments in a managed care setting, in that a school district receives a single payment for all the covered services a child needs during a specified period, such as a day or month.[8] HCFA began to allow states to develop bundled payment approaches in an attempt to simplify schools' reporting requirements under Medicaid. When appropriately used, bundled rates can help limit Medicaid costs by creating the incentive to provide needed services more efficiently. Under a bundled approach, however, costs can also be limited by neglecting to provide all needed services or by compromising the quality of individual services provided. In some cases, such a payment approach can also create an incentive for schools to change what services children receive or where they receive them to increase schools' reimbursement. The seven states that used bundled rate payments for health services account for 12 percent of total health services claims in schools. These states' rates vary in the extent to which they differentiate levels of need among children, ensure that services paid for are provided, or both. (See table 2.)

[8]Services included in the bundled rates are relatively similar among the seven states and typically include audiology; counseling; and physical, speech, and occupational therapy. One notable exception is transportation, the cost of which only four of the seven states include in their bundled rates.

Table 2: Approaches to School-Based Payments in Seven States Using Bundled Rates

State	Does the bundled rate vary depending on the needs of the child?[a]	What is the unit of payment for services?[b]	What event triggers submitting a claim to Medicaid for reimbursement?
Connecticut	No—one statewide rate	Monthly rate—$336 per child	Receipt of one service
Kansas	Yes—14 statewide rates; vary by primary disability	Monthly rate—$151–$636 per child	School attendance 1 day a month
Maine	Yes—13 statewide rates; vary by primary disability	Monthly rate—$141–$442 per child	School attendance 1 day a month
Massachusetts	Yes—seven statewide rates; vary by time spent in a regular classroom	Six daily rates—$11–$48 per child; one weekly rate—$106 per child	School attendance
New Jersey	Yes—four statewide rates; vary by type of school	Daily rate—$33–$172 per child	Receipt of one service
Utah	No—school-specific rates	Daily rate—$21–$60 per child	School attendance
Vermont	Yes—four statewide rates; vary by number of services actually provided	Monthly rate—$162–$1,598 per child	Receipt of a specified number of services

[a] States may exclude certain services, such as development and evaluation of the individualized plan of a child with a disability; the receipt of Early and Periodic Screening, Diagnostic, and Treatment services; and provision of medical equipment, from their bundled rates and separately claim Medicaid reimbursement for these services.

[b] For all but one state, the rates are current and are rounded to the nearest dollar. The rates listed for Vermont are from the 1998—99 school year. Vermont's rates have historically been adjusted annually for salary increases.

Source: State Medicaid agencies.

States do not always adjust bundled rate payments for children with different medical needs. For example, Connecticut pays the same bundled rate to all participating schools for each eligible child, regardless of whether that child has a mild learning disability or multiple physical and cognitive disabilities. The single rate may not cover the full costs incurred by schools that have a disproportionate number of children whose services cost more, which may affect schools' ability to provide necessary services. Conversely, other schools may be paid an amount higher than their actual costs. In Massachusetts and New Jersey, the payment levels vary depending on the location of the child, such as the classroom type or school in which a child is enrolled, and not necessarily on the number or scope of services provided. To a greater extent, the bundled rates in Kansas, Maine, and Vermont vary among children with different levels of need and are thus aligned more closely to the expected costs of services for specified groups of children. For example, schools in Kansas and

Maine receive the same payment amount for all children with specified disabilities, such as autism or mental retardation. Vermont does not distinguish among types of disabilities but does have four different levels of reimbursement, which vary depending on the number of services a child actually receives.[9]

In addition, states' bundled approaches may not provide adequate assurance that services paid for are actually provided. Payments in Kansas, Massachusetts, Maine, and Utah are not specifically linked to the receipt of services because reimbursement is triggered simply by school attendance. Participating schools in these states are paid the bundled rate for each eligible child, irrespective of whether the child has received any services. Better assurances that services are actually provided to eligible children exist in Connecticut, New Jersey, and Vermont. Schools in Connecticut and New Jersey must document services provided to each child to obtain the full bundled payment. In Vermont, case managers complete for each child a level-of-care form that describes the amount and scope of services provided, which determines which one of four payment levels the school receives.

Investigation Identified Improper Fee-for-Service Health Claims

Our investigation into fee-for-service school-based health services identified certain examples of inappropriate health services claims. Our investigation of practices in one fee-for-service state revealed that schools were submitting and the state was paying transportation claims for all Medicaid children who had received a Medicaid health service at school, without verifying that the child had used school bus transportation. Our investigation further identified instances in which the transportation services for which the state submitted claims were not provided, resulting in improper Medicaid reimbursements. Medicaid was also inappropriately billed for health services in two states, where some group therapy sessions were billed as individual therapy sessions, resulting in a higher payment for the schools.

[9]Schools are reimbursed a lower amount for children in level one, who receive fewer than 6 units of service a week, than for those in level three, who receive from 12 to 24 units of service a week. Vermont's approach also recognizes differences in the costs of services provided by aides and professionals. For example, 1 hour of individual therapy provided by a certified physical therapist is equal to three units of service, while an hour of therapy provided by an aide equals one unit.

For Administrative Activity Claims, Poor Controls Have Resulted in Improper Reimbursement

With regard to administrative activities, poor controls have resulted in improper payments in at least 2 of the 17 states that allowed schools to claim such costs, and the similar lack of effective controls in other states could allow comparable improprieties to occur.

- In Michigan, the HCFA Chicago regional office questioned $30 million in administrative claims for activities not clearly related to Medicaid, for the quarter ending September 1998. School staff interviewed by HCFA revealed that activities they performed, related to general health screenings, family communications, or training, had no Medicaid component or benefit, although a portion of staff time was claimed and reimbursed as such. The HCFA regional office subsequently deferred a $33 million claim made for the quarter ending September 1999, again asking the state to better document that the activities were clearly linked to Medicaid. We identified similar practices for submitting administrative claims in as many as seven other states.

- Our investigation and HCFA scrutiny of claims in Michigan and Illinois identified administrative cost claims, submitted and paid, for activities performed for the benefit of non-Medicaid-eligible children, including administrative costs related to health reviews and evaluations that specifically excluded Medicaid-eligible children for whom separate claims were submitted as direct services. Our work in Michigan alone identified $28 million in federal reimbursement for improper payments for administrative activity claims over 2 recent years.

- In Illinois and Michigan, on the advice of private firms, school districts have submitted claims that inadequately document the need to have skilled medical personnel involved in certain administrative activities. When such personnel are involved, the federal government reimburses schools 75 percent rather than 50 percent for the administrative activities they perform.[10] For recent school-based administrative activity claims in Illinois, activities performed by skilled medical personnel totaled $16.6 million, or 37 percent of the state's total claims, for one quarter for participating school districts.[11] In Michigan, this type of claim totaled $14

[10]In general, administrative activity claims based on professional credentials can be legitimately used only when the person (1) has the appropriate credential, such as a nurse, occupational therapist, or physical therapist, and (2) performs an administrative activity that requires professional knowledge and skills.

[11]For one school district, the claims were from the quarter ending December 1998; for all other school districts, the claims were from the quarter ending March 1999.

million, or 25 percent of its total administrative activity for all participating school districts, for the quarter ending September 1998.[12]

In Some States, Schools Receive a Small Portion of Medicaid Reimbursement

Funding arrangements among schools, states, and private firms can significantly reduce the amount of federal dollars that schools receive for Medicaid-related services and activities. As a result of these arrangements, a school can receive as little as $7.50 for every $100 it spends to pay for services and activities for Medicaid-eligible children. In addition, these arrangements may create adverse incentives for program oversight.

Rather than fully reimbursing schools for their Medicaid-related costs, eighteen states retain from 1 to 85 percent of federal Medicaid reimbursements (see table 3). According to several state officials, because states fund a portion of local education activities, Medicaid services provided by schools are partially funded by the state. Under this reasoning, some states believe they should receive a share of the federal reimbursements claimed by school districts. However, it is not clear that state, rather than local, funds support the Medicaid-reimbursable services as opposed to other educational activities that the states fund. Moreover, we believe that such a practice severs the direct link between Medicaid payment and services delivered, increases the potential for the diversion of Medicaid funds to purposes other than those intended, and is inconsistent with the program's fundamental tenet that federal dollars are provided to match state or local dollars to provide services to eligible individuals.

[12]In these two states, overall skilled professional medical personnel claims for administrative expenditures have increased four- and fivefold since the states began paying for school-based administrative costs.

Table 3: Federal Medicaid Reimbursement Retained by States

State	Percentage of federal reimbursement retained: Health services	Percentage of federal reimbursement retained: Administrative activities	Amount retained by state (in thousands)[a]
New Jersey	85	85	$25,815
Iowa	75	0	1,984
Delaware	70	[b]	4,865
Vermont	60	15	4,266
Alaska	[b]	52	2,023
New York	50	[b]	170,500
Pennsylvania	50	50	18,079
Washington[c]	50	0	3,122
Connecticut	40	[b]	4,443
Michigan	40	40	69,156
Wisconsin	40	40	10,749
Illinois[d]	10	10	6,391
New Mexico	5	5	314
Ohio	4	[b]	741
Utah	2	[b]	105
Colorado	2	[b]	50
Massachusetts	1	1	326
Minnesota	0	5	587
Total			**$323,516**

[a] States provided school-based claims data for the most recent fiscal year for which they were available, which for approximately half the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data from before July 1, 1997.

[b] This state does not claim reimbursement for this type of school-based activity.

[c] Washington retains at least 50 percent of federally reimbursed funds but can retain a higher percentage depending on whether the school district is "fully participating" in billing Medicaid for school-based services.

[d] When total Medicaid payments to an Illinois school district exceed $1 million in a year, 10 percent of the portion exceeding $1 million is retained for the state's general revenue fund. According to the state, 22 of its 900 school districts received more than $1 million.

Source: State-reported data.

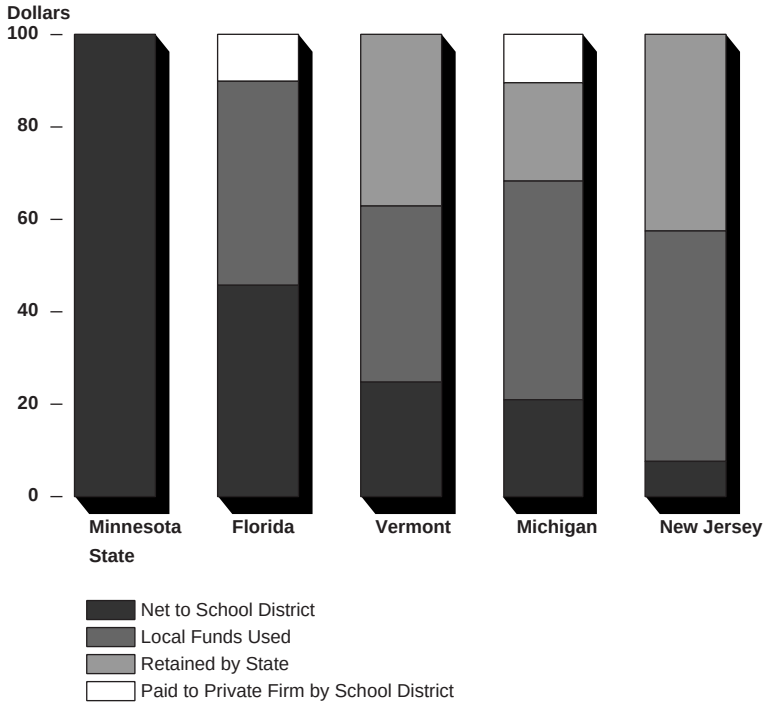
In addition, some school districts pay private firms fees ranging from 3 to 25 percent of the federal reimbursement amount claimed, with fees most commonly ranging from 9 to 12 percent. These firms are usually hired to assist with administrative cost claims, generally designing the methods used to make these claims, training school personnel to apply these

methods, and submitting administrative claims to state Medicaid agencies to obtain the federal reimbursement that provides the basis for their fees.

Finally, school districts' funds often are used to supply the state's share of Medicaid funding for school-based claims.[13] In these cases, the maximum additional funding that a school district can receive is what the federal government contributes. This is substantially less than what a private sector Medicaid provider would receive for delivering similar services. For example, a physician who submits a claim with an allowable amount of $100 will receive $100: $50 in state funds and $50 in federal funds in those states with equal matching between federal and state sources. Given the source of the states' share of funding, states' policies to retain portions of the federal reimbursement, and schools' contingency fee arrangements with private firms, the net amount of federal funds returned to a school district varies considerably. As shown in figure 3, a school district may receive as much as $100 in Minnesota to as little as $7.50 in New Jersey in federal Medicaid reimbursement for every $100 spent to pay for services and activities performed in support of Medicaid-eligible children.

[13]Local funding as the source of a state's share of Medicaid reimbursement is not unique to schools; it is most likely to exist when there are multiple governmental entities involved. For example, local funds are being used as a source of the state share of the cost of publicly funded hospitals and mental health services.

Figure 3: Some School Districts Receive Little Federal Medicaid Reimbursement



Note: For Illinois, when total payments to a school district exceed $1 million in a year, 10 percent of the portion exceeding $1 million is retained for the state's general revenue fund. In Florida, effective February 14, 2000, contingency fee reimbursement contracts are prohibited for school districts.

Source: GAO analysis of state data.

In addition to affecting the payment a school ultimately receives, these funding arrangements may create adverse incentives for program oversight. Because states can benefit directly from higher federal payments, states' incentives to exercise strong oversight over the propriety of school-based claims can be diminished. Similar questions are raised about the incentives of private firms that are paid a share of schools' Medicaid reimbursement. Embedded in both of these practices are incentives for states and private firms to experiment with "creative" billing practices, some of which we have found to be improper.

HCFA Oversight Does Not Consistently Ensure the Appropriateness of School-Based Claims

While HCFA has made some recent efforts to improve oversight of Medicaid school-based claims, efforts to date have not consistently ensured the appropriateness of these claims. For example, HCFA instructed states with bundled rates to develop and implement an alternative reimbursement methodology but did not provide a time frame in which to do so. The work group that HCFA created to explore alternatives to bundled rates included representatives from the Department of Education and some states; this group is currently inactive, and all seven states that were using a bundled approach before HCFA's May 1999 letter continue to do so while they await further guidance.

With regard to administrative activity claims, some HCFA regional offices have had little or no involvement in the development of states' methodologies for developing administrative claims, while other regional offices have worked in concert with states to develop these methodologies. Moreover, contradictory policies exist across the regional offices regarding when states may obtain the 75-percent enhanced matching rate for skilled medical providers performing administrative services. We found that different regional offices (1) allow an enhanced match, (2) completely disallow the practice, or (3) specifically review the use of the enhanced match to ensure its appropriateness. Finally, HCFA's attempt to clarify its policy on specialized transportation has resulted in inconsistency and confusion. Only one of the seven regional offices that we spoke with correctly understood that Medicaid will cover transportation costs if a child is able to ride on a regular school bus but requires the assistance of an aide. Two regional offices incorrectly believed that such costs would not be reimbursed, while four did not know whether reimbursement would be allowed.

HCFA has taken some steps to improve oversight of school-based claims. One regional office recently conducted a review of one state's practices, identified cases of improper payments, issued deferrals of claims, and is now working with a few states to revise their practices to more accurately capture the costs associated with Medicaid administrative activities in schools. Guidance that HCFA testified in June 1999 would be forthcoming was released for public comment in February 2000.

Conclusions and Recommendations

Schools are a logical place to reach Medicaid-eligible children and their families—to inform them about and encourage their enrollment in the program and to provide assistance in accessing health services. But schools' primary mission is education, not health care delivery; thus, many schools may face difficulties in understanding and navigating the Medicaid program and obtaining reimbursement for services provided. Given the

potential benefits of Medicaid-financed school-based services—which ultimately support the children who need the care and services—it is important that schools not be dissuaded from pursuing this path because of unfamiliarity with Medicaid program requirements or uncertainty about what is permissible. Approaches to obtaining federal financing for covered services and activities must therefore appropriately balance schools' needs for administrative simplicity with providing an acceptable level of assurance that services and activities paid for were actually provided.

HCFA has a critical role in this process. It must set the proper course by providing consistent policy guidance and then facilitating its interpretation and implementation across the many states and school districts that are already participating in the Medicaid program or will in the future. HCFA generally agreed with our findings and is already taking steps to respond to the recommendations set forth in our report, which address the need to

- better ensure that bundled rates for health services provide for children's varying levels of need and that services paid for were provided,
- provide consistent guidance for and monitoring of allowable administrative activities, and
- clarify policy on allowable specialized transportation costs for children with disabilities.

HCFA also expressed its commitment to work with its partners in the education community and states to address these issues in a consistent yet flexible fashion to ensure that Medicaid dollars are used only on behalf of Medicaid-eligible children for Medicaid-covered services. At the same time, the states also have an important role in this program. They share with HCFA the fiduciary responsibility to administer the Medicaid program efficiently and effectively and must also be held accountable for safeguarding public dollars while providing services to which beneficiaries are entitled.

A program of the magnitude and diversity of Medicaid—with its broad range of program goals, policymakers, providers, and beneficiaries at the federal, state, and local levels—will always present demanding challenges in terms of finding the appropriate balance between state flexibility and public accountability. The emergence of these issues associated with school-based services is just the latest example of the need for constant vigilance to guard against potential exploitation that would divert limited resources from their intended purposes. We are committed to continuing

to work with this Committee and HCFA to help address these important issues.

Mr. Chairman, this concludes our prepared statement. We would be happy to answer any questions that you or Members of the Committee may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, call Kathryn G. Allen at (202) 512-7118; for questions regarding our investigation, call Robert H. Hast at (202) 512-7455. Staff who made key contributions to this testimony include Carolyn L. Yocom, Susan T. Anthony, Connie Peebles Barrow, Laura Sutton Elsberg (Health, Education, and Human Services Division); William Hamel and Andrew A. O'Connell (Office of Special Investigations); Ray Bush and Paul D. Shoemaker (Atlanta Field Office); and Daniel Schwimer and Richard Burkard (Office of the General Counsel).

Appendix: States' Annual School-Based Claims, Ranked by Average Claim Per Medicaid-Eligible Child Aged 6 to 20

	School-based claims (in thousands)			
State	**Average claim per Medicaid-eligible child**	**Total claims**	**Health claims**	**Administrative claims**
Maryland	$818	$93,824	$93,824	[a]
New York	703	682,000	682,000	[a]
Illinois	674	385,633	82,946	$302,687
Michigan	674	317,701	93,534	224,167
New Hampshire	658	24,894	24,894	[a]
Rhode Island	600	27,482	27,482	[a]
Delaware	394	13,900	13,900	[a]
Maine	350	22,000	22,000	[a]
Vermont	309	12,798	11,041	1,757
Kansas	291	25,741	25,741	[a]
Massachusetts[b]	284	65,250	45,750	19,500
Alaska	265	7,780	[a]	7,780
District of Columbia	265	12,100	12,100	[a]
Wisconsin[c]	249	45,904	44,312	1,591
New Jersey	248	66,328	60,671	5,657
Connecticut	174	22,216	22,216	[a]
Pennsylvania	121	68,507	54,555	13,952
Arizona	115	25,795	[a]	25,795
Utah	114	7,279	7,279	[a]
Minnesota	105	23,766	271	23,495
Texas	88	78,030	66,368	11,662
Washington	87	30,367	11,973	18,394
Oregon	85	12,441	12,441	[a]
South Carolina	79	14,247	14,247	[a]
New Mexico	72	10,348	5,439	4,909
Ohio	66	31,953	31,953	[a]
Florida	59	41,518	3,067	38,451
Nebraska	58	3,916	3,916	[a]
Missouri	55	15,381	4,277	11,104
Iowa	52	5,255	4,171	1,084
Nevada	48	1,900	1,900	[a]
Arkansas	45	5,428	5,428	[a]
Colorado[d]	44	4,885	4,885	[a]
North Dakota	41	826	826	[a]
South Dakota	31	906	906	[a]
Montana	29	892	892	[a]
Louisiana	26	6,269	6,269	[a]
West Virginia	24	3,044	3,044	[a]
Georgia	21	9,167	9,167	[a]
Idaho[d]	20	781	781	[a]
California	19	42,308	42,020	288
Oklahoma	10	1,311	1,311	[a]
Kentucky	6	1,228	1,228	[a]
Virginia	5	1,201	1,201	[a]

Appendix: States' Annual School-Based Claims, Ranked by Average Claim Per Medicaid-Eligible Child Aged 6 to 20

State	School-based claims (in thousands)			
	Average claim per Medicaid-eligible child	Total claims	Health claims	Administrative claims
North Carolina	2	722	722	[a]
Alabama	1	132	132	[a]
Indiana	[e]	60	60	[a]
Mississippi	[e]	8	8	[a]
Hawaii	[a]	[a]	[a]	[a]
Tennessee	[a]	[a]	[a]	[a]
Wyoming	[a]	[a]	[a]	[a]
Total		**$2,275,423**	**$1,563,150**	**$712,273**

Note: States provided school-based claims data for the most recent fiscal year for which they were available, which for approximately half the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data for periods before July 1997.

[a] This state did not report school-based claims.

[b] Massachusetts provided 6 months of administrative claims data, which we extrapolated to reflect a full year of claims.

[c] Wisconsin's school-based health claims and administrative claims do not equal its total school-based claims because of rounding.

[d] Colorado and Idaho provided 11 months of health services claims data, which we extrapolated to reflect a full year of claims.

[e] The average claim per Medicaid-eligible child was less than $1.

Source: GAO analysis of state-reported claims data and HCFA's fiscal year 1997 eligibility data (2082 report).

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